

FILED JAN 11 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41539

BIRTH NO. _____		REG. DIST. NO. 226		PRIMARY REG. DIST. NO. 4336		Registrar's No. 55	
1. PLACE OF DEATH a. COUNTY Monroe County				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Monroe 0690			
b. CITY (If outside corporate limits, write RURAL and give town) Holliday, Mo.		c. LENGTH OF STAY (If in this place) 40 yrs		c. CITY (If outside corporate limits, write RURAL and give township) Holliday, Mo. 7 miles N.		0	
d. FULL NAME OF HOSPITAL OR INSTITUTION None				d. STREET ADDRESS (If rural, give location) X			
3. NAME OF DECEASED (Type or Print)		a. (First) Julia Lue Ensor		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 12-16-1950	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 6-6-1879	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) Holliday, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Sidney A. Sanders		13b. MOTHER'S MAIDEN NAME Frances Burton		14. NAME OF HUSBAND OR WIFE Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. X		17. INFORMANT'S SIGNATURE OR NAME Local Ensor, Holliday, Mo. ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral embolism		INTERVAL BETWEEN ONSET AND DEATH 24 Hrs			
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? 332X YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 11, 1950 , to Dec 16, 1950 , that I last saw the deceased alive on Dec 16, 1950 and that death occurred at 5:45 P.M. from the causes and on the date stated above.							
23a. SIGNATURE Anna M. Budditt (Type or Print)				23b. ADDRESS Shelbina, Mo.		23c. DATE SIGNED 12-18-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-19-1950		24c. NAME OF CEMETERY OR CREMATORY Shelbina Cemty.		24d. LOCATION (City, town, or county) (State) Shelbina, Mo.	
DATE REC'D BY LOCAL REG. 12-21-50		REGISTRAR'S SIGNATURE Anna M. Budditt		25. FUNERAL DIRECTOR'S SIGNATURE Barkelaw-Hawkins, Shelbina, Mo. ADDRESS			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Date Received: JAN 4 1951
DISTRICT HEALTH OFFICE #2
District File Number 1-51-4
Date Filed: JAN 10 1951

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Student Embalmer No. _____

Licensed Embalmer No. 3498

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.